Health Policy Committee
Office of Representative
Marc R. Corriveau - Chair

HEALTH POLICY COMMITTEE
Terminology

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Academic Detailing - On site educational outreach to improve physicians' and other prescribers' clinical decision-making in order to enhance the quality and cost-effectiveness of care.

Adverse Selection - A tendency of people only purchasing insurance when they are sick and have significant expenses. To expend, utilization of healthcare services in a population group to be higher than average. Occurs when persons with poorer than average health apply for, or continue, insurance coverage to greater extent than persons with average or better health expectations.

All-Payer System - A system in which prices for health services and payment methods are the same, regardless of who is paying. For instance, in an all-payer system, federal or state government, a private insurer, a self-insured employer plan, an individual, or any other payer could pay the same rates. The uniform fee bars health care providers from shifting costs from one payer to another.

Ambulatory Care - All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services that do not require an overnight stay.

Annual Administrative Fee - Charge for expenses associated with administering a group employee benefit plan.

Annual or Lifetime Benefit Caps - The maximum amount health insurance plans cover claims for plan members during a one-year period (annual

benefit cap) or throughout that individual's membership (lifetime benefit cap).

Anonymous Reporting – An error reporting method used to protect the identity of those individuals who report medical errors so that their reports cannot be easily used in civil lawsuits against them. Under anonymous reporting, data that could identify the reporter are omitted from the report.

Avoidable Hospital Condition – Medical diagnosis for which hospitalization could have been avoided if ambulatory care had been provided in a timely and efficient manner.

Benefits – See Coverage

Biased Selection – The market imperfection that results from the uneven grouping of risks among competing subscribers. Biased selection includes favorable selection (attracting good risks and repelling bad ones) as well as adverse selection (the reverse).

Blue Cross Plan – A nonprofit, tax exempt insurance plan providing coverage for hospital care and related serves. (The individual plans should be distinguished from their national association, the Blue Cross Association) Historically, the plan was largely the creation of the hospital industry and designed to provide hospitals with stable source of revenue. A Blue Cross plan should be a nonprofit community services organization with a governing body whose membership includes majority of public representatives.

Budget Neutrality – A health expansion plan in which new costs are balanced by spending cuts elsewhere, so that overall spending remains unchanged. Medicaid waivers often carry a budget neutrality requirement by the federal government.

Carrier – A private organization, usually an insurance company that finances health care.

Carve Out – Regarding health insurance, and arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services, and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement.

Carve our may also refer to a method of coordinating dual coverage for an individual.

Catastrophic Health Insurance - health insurance that provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all or a specific percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

Catastrophe Reinsurance - Reinsurance for catastrophic losses. The insurance industry is able to absorb the multibillion dollar losses caused by natural and man-made disasters such as hurricanes, earthquakes and terrorist attacks because losses are spread among thousands of companies including catastrophe reinsurers who operate on a global basis. Insurers' ability and willingness to sell insurance fluctuates with the availability and cost of catastrophe reinsurance. After major disasters, such as Hurricane Andrew and the World Trade Center terrorist attack, the availability of catastrophe reinsurance becomes extremely limited.

Certificate of Need - A regulatory process that requires hospitals and other health care facilities to obtain state approval before offering certain new or expanded services. Intended to control expansion of facilities and serves by preventing excessive or duplicative development of facilities and services.

Centers for Medicare and Medicaid Services (CMS) - The government agency within the department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. Formerly the Health care Financing Administration (HCFA).

Certificate of Need (CON) - A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer anew or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services.

Charity Care - Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services,

especially those who are low-income, uninsured, and underinsured. A high proportion of the costs of charity care is derived from services for children and pregnant women (e.g., neonatal intensive care).

Cherry Picking - The ability to offer selected coverage, such as young and health but deny coverage to people who are older or sicker.

Chronic Care - Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

Closing Block of Business - A particular individual policy or contract providing hospital , medical or surgical expense, long-term care or Medicare supplement coverage issued by a carrier to one or more individuals which includes distinct benefits, services and terms that the carrier ceases to actively offer or sell to new applicants.

Cobra - A health insurance plan which allows an employee who leaves a company to continue to be covered under the company's health plan, for a certain time period and under certain conditions. The name results from the fact that the program was created under the Consolidated Omnibus Reconciliation Act. The system is designed to prevent employees who are between jobs from experiencing a lapse in coverage.

Commission - Fee paid to an agent or insurance salesperson as a percentage of the policy premium. The percentage varies widely depending on coverage, the insurer, and marketing needs.

Community Rating - A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers to reflect their specific claims experience or health status. Under modified community rating (the most common form), rates may vary based on subscribers' specific demographic characteristics (such as age and gender), but rate variation based on individuals' health status, claims experience, or policy duration is prohibited. "Pure" community rating prohibits rate variation based on demographic as well as health factors, and all subscribers in an area pay the same rate.

Connector - A common marketplace of health insurance options for individuals.

Consumer - One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

Copayments - A fixed amount of money paid by a health plan enrollee (beneficiary) at the time of service. For example, the enrollee may pay a $10 "copay" at every physician office visit, and $5 for each drug prescription filled. The health plan pays the remainder of the charge directly to the provider. This is a method of cost-sharing between the enrollee and the plan, and serves as an incentive for the enrollee to use healthcare resources wisely. An enrollee might be offered a lower price benefit package in return for a higher copayment.

Coverage - The guarantee against specific losses provided under the terms of an insurance policy. Coverage is sometimes used interchangeably with benefits or protection, and is also used to mean insurance or insurance contract.

Crowd-Out - A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

Deductible - The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed-dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g., $100 per calendar year, benefit period, or spell of illness.

Disproportionate Share (DSH) Adjustment - A payment adjustment under Medicare's prospective payment system or under Medicaid for hospitals that serve a relatively large volume of low-income patients.

DSH (Disproportionate Share Hospital) Funding - Funding (mainly from the federal government, through Medicaid) to hospitals that serve a relatively large volume of uninsured and low-income patients.

ERISA (Employee Retirement Income Security Act of 1974) - A federal law that governs employee benefit programs and includes general protections about benefits and the disclosure of information. Among other policies, ERISA prevents states from making laws that directly regulate an employer's heath plans if the employer "self insures." ERISA also prohibits states from requiring employers to provide health benefits.

Federal Match - For the Medicaid and SCHIP programs, the federal government "matches" states' contributions by at least 50%. The matching rate varies by state and program.

Federal Poverty Level (FPL) - The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. FPL is reported annually and varies according to family size (e.g., for a family of three in 1999, the FPL was $13,880, or $1,157 per month). Public assistance programs usually define income limits in relation to FPL.

Fee-For-Service - This refers to health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service.

Formulary (or PDL, Preferred Drug List) - The list of drugs that a health plan will cover, either fully or in part. Formularies vary by health plan. Depending on the plan, drugs not on the list may require that the recipient pay out of picket completely or pay a higher co-payment.

Fully Insured Plan - An employer that is "fully insured" enters into a contract with a health insurance company to handle health benefits for its workers. The employer pays premiums to an insurer, and, in exchange, the insurer pays health care claims and bears the risk for claims.

Go-Bare Period - A requirement that people remain uninsured for a period of time before they enroll in a public health insurance program, unless they have recently lost a job where they had employer-sponsored coverage. (This practice is common in state SCHIP and other public insurance programs.)

Group Conversion - When your group health insurance ends, your health plan may have to offer you an individual plan. This is called a conversion plan because you convert from the group to an individual plan. If you qualify for a conversion plan, you cannot be denied insurance because of your medical history.

Guaranteed Issue - A requirement that insurers sell insurance policies to anyone who seeks, one, regardless of health, income, age or other factors. Not all carriers are subjected to this requirement.

Guaranteed Renewal - Requirement that insurance carriers renew existing coverage to groups and/or individuals. HIPAA requires that insurance issuers guarantee renewal of all products to all groups of individuals.

Health - The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) - Sometimes referred to as the Kennedy-Kassebaum bill, this legislation sets a precedent for Federal involvement in insurance regulation. It sets minimum standards for regulation of the small group insurance market and for a set group in the individual insurance market in the area of portability and availability of health insurance.

Health Information Technology - Computerized records and other tools to streamline healthcare using advanced technology.

Health Maintenance Organization (HMO) - An entity with four essential attributes: (1) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the deliver of (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amount of actual services provided to an individual enrollee. Individual practice associations involving groups of independents physicians can be included under the definition.

Health Plan - An organization that provides a defined set of benefits. This term usually refers to an HMO-like entity, as opposed to an indemnity insurer.

Health Underwriting - The practice of a health insurer assessing the risk of a group or individual based on prior health history (if allowed by law), geographic area, and/or a number of other factors in order to determine the premiums necessary to insure a group or individual.

High-Risk Pool - A subsidized health insurance pool organized by some States as an alternative for individuals who have been denied health insurance because of a medical condition, or whose premiums are rated significantly higher than the average due to health status or claims experience. Commonly operated through an association composed of all health insurers in a State. HIPAA allows States to use high-risk pools as an "acceptable alternative mechanism" that satisfies the statutory requirements for ensuring access to health insurance for certain individuals.

HMO - Acronym for Health Maintenance Organization. An organization that arranges a wide spectrum of health care services which commonly include hospital care, physicians' services and many other kinds of health care services with an emphasis on preventive care. Services are provided by physicians who are employed by, or under contract with, the HMO.

Hospice - A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed, and cared for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

Individual Mandate - A law that requires all residents to obtain health insurance.

Individual Market - See Non-Group Market.

Insurer of Last Resort - An insurance plan that accepts 'uninsurable' persons who have expensive and/or chronic diseases, and cannot obtain coverage at market rates.

Large Group Insurance Market – The market that sells plans to employers who are larger than a certain size. The cut-off for large groups varies from state to state. Large group insurance is not a guaranteed issue, but large groups often enjoy a greater variety of available plans than small groups.

Long-Term Care – A set of health care, personal care, and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care and assisted living, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

Loss Ratio – The ratio of incurred losses and loss adjustment expenses (the expenses incurred to investigate and settle claims) to net premiums earned. This ratio measures the company's underlying profitability, or loss experience, on its total book of business.

Mandated Health Insurance Benefits – Minimum health insurance coverage requirements specified by government statute.

Medicaid Managed Care Organizations (MCOs) – Managed care organizations that provide services to Medicaid beneficiaries. A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and directs the use of medical care services using a monthly captivated payment.

Medicaid (Title XIX) – A Federally aided, State-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, States determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicaid Waiver – Sections 1115 and 1915 of the Social Security Act define specific circumstances under which the federal government may, at

a state's request, "waive" certain provisions of the federal Medicaid laws. The "waiver" is the agreement between the federal government and the state that exempts the state from these provisions and includes special terms and conditions that define who may be covered. For example, some states use Medicaid waivers to extend Medicaid coverage to adults who do not have dependent children and who are disabled – a group that does not ordinarily qualify for Medicaid under federal law.

Medical Home – A primary care practice where a patient's health history is known, and where a patient routinely seeks medical care.

Medical Loss Ratio – The percentage of premium dollars an insurance carrier spends on medical care. State rules may set this amount, as opposed funds spent on administrative costs and marketing. This does not include administrative expenses, commissions, and profit.

Medicare (Title XVIII) – A U.S. health insurance program for people aged 65 and over, for persons eligible for Social Security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Medicare Savings Program – Medicare Savings Programs provide eligible Medicare beneficiaries with financial assistance for Medicare premiums and cost-sharing. There are several different programs for beneficiaries:
1) Qualified Medicare Beneficiaries (QMBs) have their Medicare Part B premiums paid through federal and state Medicaid matching funds. In addition, if they see health providers who accept Medicaid, QMBs do not have to pay cost-sharing for Medicare services.
2) Specified Low-Income Medicare Beneficiaries (SLMBs) also have their Medicare Part B premiums paid by federal and state Medicaid-matching funds. However, SLMBs are responsible for cost-sharing for Medicare services, which is typically 20% of charges for doctor visits.
3) Qualified Individuals (QIs) have their Medicare Part B premiums paid through a federal block grant to state Medicaid agencies. However, QIs are responsible for cost-sharing for Medicare, and if the state exhausts its block grant funds, the state is not required to continue paying premiums for QIs.

Medical Underwriting - Medical underwriting is the practice that allows insurance carriers in the market to decide whom to sell coverage to, what benefits to offer, and what premiums to charge based on a number of criteria, including health status, prior medical claims, age, gender, and other factors. Medical underwriting is common in the individual insurance market, but is prohibited in some states. Many states have some restrictions on medical underwriting, or provide other options, such as high risk pools, to individuals turned down for insurance.

Medigap - Medicare Supplement Insurance, also known as "Medigap" insurance, provides supplemental health insurance coverage for Medicare beneficiaries. Individuals in the "original" Medicare program may want to obtain Medicare Supplement ("Medigap") insurance because Medicare often covers less than the total cost of the beneficiary's health care. Medigap policies are strictly regulated by Federal rules.

Modified Community Rating - A method of determining rates for health insurance premiums based on data from a given geographic area.

Monthly Capitation - A monthly fee per person, rather than a payment per claim, in a managed care plan.

Non-Group Market (Individual Market) - This refers to the health insurance market that can be bought directly from an insurer, rather than through a group (such as an employer).

Non-Profit Plans - Insurance plans which cannot sell shares of stock and which must operate in the interest of the public good. In return, they often receive a tax benefit.

Open Enrollment - A method for ensuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

P.A. 350 - Michigan statute that governors Blue Cross Blue Shield of MI as insurer of last resort.

Pay for Performance - The idea that there should be a direct linkage between what is paid for health services and the value of the services purchased. Pay-for-performance changes reimbursement methods to reward providers for providing higher quality and efficient care.

Pay or Play - The policy that provides employers the choice of whether to "play" by providing health care benefits to their employees or "pay" by paying money to the state.

Potentially Preventable Conditions (PPCs) - Also called "never events," these are mistakes by medical providers that often lead to harmful conditions for patients.

PPO - Acronym for Preferred Provider Organization Plan. A network-based, managed care plan that allows the participant to choose any health care provider. However, if care is received from a "preferred" (participating in-network) provider, there are generally higher benefit coverage and lower deductibles.

Preexisting Condition - A medical condition developed prior to issuance of a health insurance policy. Some policies exclude coverage of such conditions is often excluded for a period of time or indefinitely.

Preferred Provider Organization (PPO) - Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.

Premium Assistance - The use of public funds to purchase (or subsidize the purchase of) private insurance.

Primary Care Case Management (PCCM) - The use of primary care physicians to manage all medical and surgical care for patients, typically structured through a fee-for-service system.

Primary Payer - The insurer obligated to pay losses before any liability is assumed by other, secondary insurers. Medicare, for instance, is a primary payer with respect to Medicaid.

Prospective Payment - Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a defined period (usually a year).

Provider - Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

Rate Bands - The allowable variation in insurance premiums as defined in state regulations. Acceptable variation may be expressed as a ration from highest to lowest (e.g., 3:1) or as a percent of the index rate (e.g., +/- 20 percent). It is used to limit variation for individual factors (such as age, gender, occupation, or geographic region) or limit variation for all of these factors together (called a composite rate band).

Rate Review - Review by government or private agency of a hospital's budget and financial data, performed for the purpose of determining the reasonableness of the hospital rates and evaluating proposed rate increases.

Reinsurance - The resale of insurance products to a secondary market, thereby spreading the costs associated with underwriting.

Rejection rates - The frequency with which applicants are denied the sale of health insurance by a health insurance provider.

Rescission - The termination of a contract with the insured. The insurer has the right to rescind a policy because of concealment, material misrepresentation, or material breach of warranty.

Reserve - An amount representing actual or potential liabilities kept by an insurer to cover debts to policyholders. A reserve is usually treated as a liability. (please see risk-based capitol).

Risk-Based Capital - a method developed by the NAIC to measure the minimum amount of capital that an insurance company needs to support its overall business operations. Risk-based capital is used to set capital requirements considering the size and degree of risk taken by the insurer. As the current measurement stands there are four major categories of risk that must be measured to arrive at an overall risk-based capital amount.

Risk-Based Capital Formula - A method of establishing the minimum amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size, structure, and risk

profile. It is used to assess a managed care organization's financial viability and help prevent insolvency.

Risk Pool - *see high-risk pool*

Safety Net - The network of providers and institutions that provide low cost of free medical care to medically needy, low income, or uninsured populations. The health care safety net can include (but it no limited to) individual practitioners, public and private hospitals, academic medical center, and smaller clinics or ambulatory care facilities.

Section 125 Cafeteria Plans - (so called after Section 125 of the Internal Revenue Code) Allow employees to set aside pre-tax dollars for health benefits even if the employer does not contribute to the employee's premium. Some states encourage or require certain businesses to establish cafeteria plans so that their workers will be able to pay for premiums with pre-tax dollars.

Section 1115 Medicaid Waiver - Section 1115 of the Social Security Act grants the Secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects that are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements, the scope of services available, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing provider, and the statewide application of the program.

Self-Funding/Self-Insurance - An employer or group of employers sets aside funds to cover the cost of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service-only agreement with an insurance carrier or third-party administrator. Under self-funding, it is generally possible to purchase stop-loss insurance that covers expenditures about a certain aggregate claim level and/or covers catastrophic illness or injury when individual claims reach a certain dollar threshold.

Self-Insured Plan - A health plan in which the employer assumes the financial risk of covering its employees, paying medical claims from its own resources.

Small-Group Market - The insurance market for products sold to groups that are smaller than a specified size, typically employer groups. The size of groups included usually depends on state insurance laws and thus varies from state to state, with 50 employees as the most common size.

Social Mission - A term used by non-profit organizations to express their goals in terms that differentiate them from those of for-profit organizations.

State Children's Health Insurance Program (SCHIP) - This program was enacted as part of the Balanced Budget Act of 1997, which established Title XXI of the Social Security Act to provide States with $24 billion in Federal funds for 1998-2002 targeting children in families with incomes up to 200 percent of the Federal poverty level.

Standardized Benefit Plans - A state can set certain standards for health coverage benefits and cost-sharing.

State-Mandated Benefits - In order to sell health insurance, insurers must cover certain services and providers, which vary by state.

State Plan Amendment - A proposed change to a state's Medicaid plan, which must be submitted to the Centers for Medicare and Medicaid (CMS).

Surplus - The amount by which assets exceed liabilities.

Tax-Exempt Status - An exemption from all or particular taxes levied by the state or federal government in order to promote economic activity of a particular nature. Tax-exempt status is typically given to charitable or public organizations.

TEFRA - The TEFRA option, also known as the "Katie Beckett option," allows states to cover home and community based care for disabled children who are not in residential programs. Eligibility depends upon the level of disability and care needed by the child, rather than the family's income. Under this option, states can avoid institutionalizing children in skilled nursing facilities.

Title XVIII (Medicare) - The title of the Social Security Act that contains the principal legislative authority for Medicare program and therefore a common name for the program.

Title XIX (Medicaid) - The title of the Social Security Act that contains the principle legislative authority for the Medicaid program and therefore a common name for the program.

Trend - also commonly known as medical inflation.

Uncompensated Care - Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

Uncompensated Care Funds - Funds used to pay for physician or hospital services when no payment is received from the patient or from insurance. Sometimes, uncompensated care is defined to include costs that come from cost-shifting or bad debt, as well as charity care; other times, uncompensated care is defined to exclude bad debt and only refer to care for people who are determined in advance to be in need of care at no charge.

Underinsured - People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

Uninsurables - High-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of risks of standard health underwriting practices.

Uninsured - People who lack public or private health insurance.

Underwriting - In insurance, the process of selecting, classifying, evaluating, and assuming risks according to their insurability. Its purpose is to make sure that the group or individual insured has the same probability of loss and probable amount of loss, which reasonable limits, as the universe on which premiums rates were based. Since premium rates are based on an expectation of loss, the underwriting process must classify risks into groups with about the same expectation of loss.

Utilization - Use. Commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., hospital care, physician

visits, and prescription drugs). Use is also expressed in rates per unit of population at risk for a given period.

Wellness - A dynamic state of physical, mental, and social well-being. A way of life that equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses. A lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

Wrap-Around Benefits - Medicaid, as a secondary insurer, is able to pay for benefits not covered by a private plan. This is often utilized in premium-assistance programs.

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